moving in the right direction

SEEI FINAL REPORT

MARCH 31, 2009

seei

systems
enhancement
evaluation
initiative

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Ontario

OMHF The Ontario Mental Health Foundation
La Fondation ontarienne de la santé mentale

CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE, ONTARIO

Ontario Federation of Community Mental Health and Addiction Programs

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Foreword

This report provides a high level summary of the results of the Systems Enhancement Evaluation Initiative (SEEI) that has over the past four years been studying what happens when a province invests a considerable sum of additional funds into its community mental health system. The unique opportunity was created through the combined efforts of enlightened government decision makers in several ministries in Ontario who flowed new dollars into ongoing and new programs primarily serving those with severe mental illness.

The SEEI included a number of different approaches to learning about the process and outcomes of such an extraordinary influx of new resources. Various types of programs and levels of the system were studied using a mix of different methods and data sources. The one constant was a commitment to conduct applied research that involved those who had a stake in the results. There were a number of challenges associated with studying a policy implementation of such scope. The evaluation had to happen in real time as the new program enhancements were occurring in order to capture a baseline picture, but this meant that the full effects of the changes which can take years to occur could not be captured. The organizational environment in which the programs and services were operating was undergoing tremendous change which limits the ability to draw straight lines between the introduction of new resources and outcomes for those who are served by the system. Still, the situation created an unusual learning opportunity, to describe and to understand what occurs when government takes very seriously the need to expand and improve the services and supports that are offered to clients and their families in the community.

What follows is a description of some of what has been learned from the nine different SEEI studies. It is impossible in a brief report to do justice to the breadth and depth of all that has been gleaned from the initiative. Instead, we are providing a taste of what is available in the separate study reports in the hopes that readers will be motivated to read and learn more by retrieving the primary sources and contacting the appropriate people. We have summarized some of the key messages that, for the most part, arise from more than one study, providing examples for illustration.

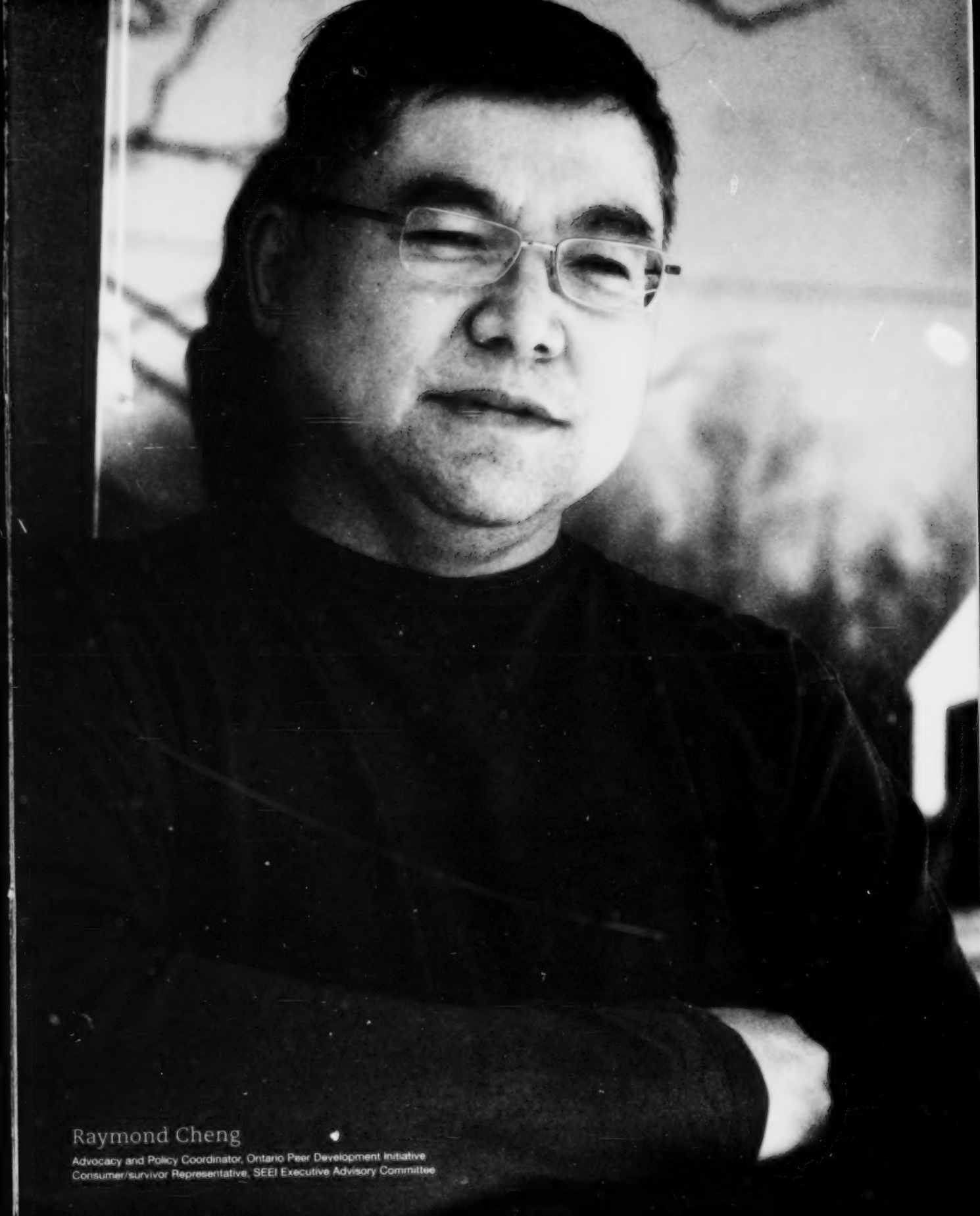
It is clear that the process of program and system change is a complex and never-ending development. The data and results that we are reporting provide us with both answers and questions about the influence of new funding upon various aspects of the system and upon various aspects of the lives of clients and families. Some of what we found is unexpected and leads to head scratching and reflection. A lot of what we are reporting confirms that the investments are paying off and that we are indeed "moving in the right direction." The process of collecting and reflecting upon all of the observations has been a collaborative educational activity that we hope will continue over the coming months and years.

An initiative of this size and duration requires the energy and commitment of a wide array of different individuals and organizations. Because of the participatory approach that was common to all projects, the number of players was greater than would have been the case with a more traditional research evaluation.

A special vote of thanks to the investigator leads and teams of each of the projects is needed to recognize the extra effort that it takes to design and conduct such field evaluations. Their research staff have worked hard and well to realize ambitious plans. Our Ministry of Health and Long Term Care partners and funders have worn their many hats with ease and skill that made the whole endeavor much easier to pull off. The Ontario Mental Health Foundation provided us with an administrative home that is compatible with a different way of doing business. An Executive Advisory Committee provided guidance and support to all aspects of the initiative. Coordinating Centre staff facilitated the knowledge exchange activities and built the Ontario Mental Health and Addictions Knowledge Exchange Network that helped to connect the projects with the field.

The most precious contribution for an initiative like this is the goodwill and cooperation of those who are being studied. Service providers from more than 100 of the 300 community mental health programs in the province participated in one or more of the projects with remarkable willingness to give of their time and experience. The response of hundreds of clients and family members was also gratifying and essential to achieving the aims of the evaluation. We hope that your participation feels worthwhile and that you will read these findings with great interest and a sense of shared accomplishment.

Because of the participatory approach that was common to all projects, the number of players was greater than would have been the case with a more traditional research evaluation.



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Program Capacity & Access:

- Programs substantially increased the number of clients they were able to serve. Examples include the multi-site study of early intervention and court support programs, and an integrated crisis-case management service. However, the newly enhanced community mental health system still does not have the capacity to serve all those in need.

Program Client Outcomes:

- Clients of newly-enhanced programs experienced a range of positive outcomes, such as reduced homelessness, reduced need for hospital resources, and a greater ability to live independently in the community. Studies which found positive outcomes include the court support program in Ottawa, and the multi-site study of early intervention and court support programs.

Program Innovation:

- New funds were used to innovate and develop more efficient and effective program-level services. Examples include the integrated crisis-case management service in Kingston and the community-based discharge planning service in Sarnia.

System Integration:

- System integration was expanded and improved when funds were targeted specifically towards integration activities. The Waterloo Wellington regional crisis system illustrates this change well.

System Capacity & Access:

- Demand on other parts of the system may be increased when only certain programs are enhanced and more clients are engaged in treatment. The multi-site study of court support programs demonstrates this impact.

- Matching the level of care that client's need with the level they receive has improved. In addition, access to care at the regional community mental health system level has increased. There are, however, still many people receiving less than recommended levels of care. This is illustrated by the study of Southeastern Ontario's community mental health system.

Impact on Hospital Use:

- Findings about impacts on hospitals varied according to whether the scope of the study was program-specific, regional or province-wide. At the province-wide system-level, demand increased on hospital emergency rooms, even as early return rates to emergency rooms decreased. Southeastern Ontario's community mental health system experienced an overall increase in demand on hospital resources. The multi-site study of court support and early intervention programs found evidence of some decreased reliance on hospital resources.

Interaction with the Police/ Criminal Justice:

- Court support programs and workers played a "boundary spanning" role. The enhancement of court support programs situated inside the criminal justice system helped to facilitate limited improvements inside that system. These improvements are limited due to the narrow reach of court support programs in relation to the population in need of service.

- Mental health related contacts and apprehensions by officers under the Mental Health Act increased at the provincial level, with some variation across regions. The Waterloo Wellington regional crisis system showed a reduction in Mental Health Act apprehensions, despite an increase in mental health related calls.
- There were frequent partnerships between police and mental health services for training and on-site response across the province, with a considerable amount of activity taking place since 2005.

Broader Supports and Services:

- Clients lack access to a range of broader services and supports such as housing, transportation and vocational supports, and face challenges of poverty, unemployment and a lack of education.

Follow up Technical Assistance and Monitoring:

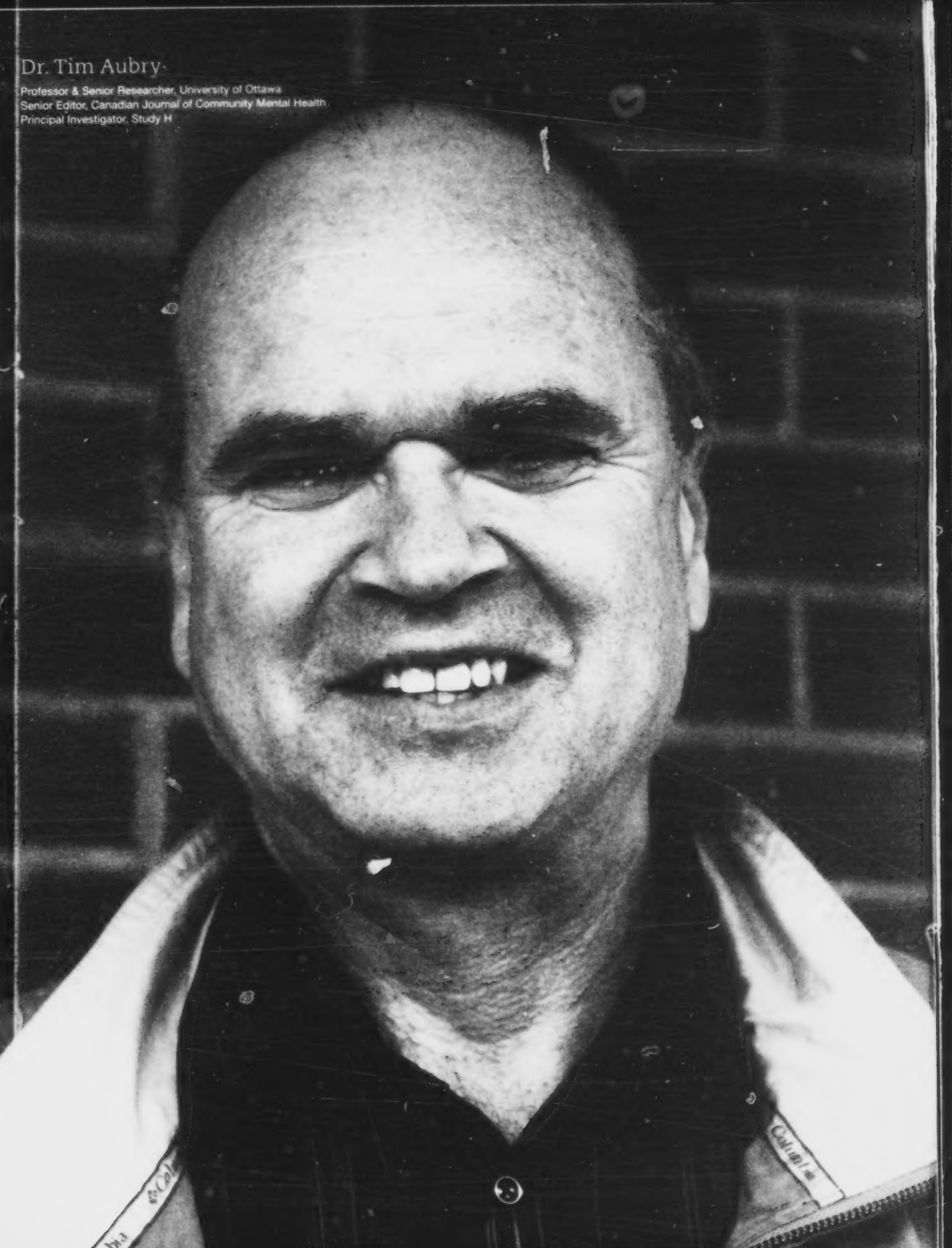
- Provision of follow-up technical assistance and monitoring would help to support and address challenges identified in different parts of the system. For example, while ACT teams across the province showed high fidelity to the ACT model according to most measures, they continued to face difficulties with achieving the standard caseload ratio and hiring and retaining staff with the right skills and training.

Provision of follow-up technical assistance and monitoring would help to support and address challenges identified in different parts of the system.

Lessons learned from the Evaluation Process:

- The field had mixed experiences with initiating the new investments, discovering that there are particular facilitators and barriers to the process of rolling out new funds.
- It takes time before the full impacts of system enhancements can be seen, suggesting that not all study results reflect the full impact of the enhancements and that there is a need for continued research and evaluation.
- Hiring and retaining staff with the rights skills and training is a challenge.
- Doing an evaluation with the active engagement of stakeholders can help to create positive change within the system.

Programs substantially increased the number of clients they were able to serve. However, the newly enhanced community mental health system still does not have the capacity to serve all those in need.



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1.

The Systems Enhancement Evaluation Initiative (SEEI) is an innovative multi-faceted four-year evaluation of the significant investments made by the Government of Ontario in specific areas of the community mental health system. The Ministry of Health and Long Term Care's (MOHLTC) financial investment provided a 52% increase in funding to the province's community mental health system, starting in 2004. These additional funds were an attempt to redress significant gaps previously identified in the community mental health system.[1]

The new investments emerged from two provincial initiatives.

1) The Federal Health Accord for Home Care stipulated that funds target the needs of people who meet the criteria for homecare. Ontario was the only province that targeted a portion of these funds for the community mental health system, totaling $117 million over four years in these areas:

- Intensive case management (ICM),
- Assertive community treatment (ACT),
- Crisis intervention, and
- Early intervention services.

2) The Service Enhancement Initiative is the result of an inter-ministerial government partnership involving the MOHLTC and four other Ministries:

- Ministry of Community & Social Services
- Ministry of Community Safety & Correctional Services
- Ministry of Attorney General
- Ministry of Children & Youth Services

The Initiative was designed to direct people with mental illness away from police, the criminal justice and corrections system. Fifty million dollars was allocated in 2005 and 2006, for:

- Court support programs,
- ICM,
- Crisis interventions,
- Supportive housing, and
- Safe beds.

In early 2005, the MOHLTC asked the Health Systems Research and Consulting Unit (HSRCU) at the Centre for Addiction and Mental Health (CAMH) to coordinate an evaluation of the effects of the Government of Ontario's investments in targeted areas of the community mental health system. In response, SEEI was developed. SEEI is comprised of nine research studies and a knowledge exchange network. Further detail about the scope, focus and main findings of each of the studies is provided later in the report and in Appendix 1.

The HSRCU at CAMH acted as the Coordinating Centre for the overall initiative, and was home to two of the research studies.

The vision for the evaluation from the outset was that it should assess the impact of additional investments at the time that funds were being applied at the program or system level, or shortly thereafter. As it takes time before new investments lead to the establishment and mature functioning of programs, researchers were faced with the challenge of evaluating programs and systems that were

1 Mental health services in Ontario: How well is the province meeting the needs of persons with serious mental illness? Koegl, C., Durbin, J. & Goering, P. Health Systems Research & Consulting Unit, Centre for Addiction and Mental Health. 2004

in the process of changing, sometimes working with imperfect pre-existing data sets. But the approach provided stakeholders with the opportunity to use results to improve the system as it was being enhanced, helping to ensure better experiences and outcomes for clients sooner in the evaluation process. Stakeholders also gained a sense of how the investments were affecting outcomes.

The SEEI represents a broad collaboration of researchers, consumer/survivors, family members, service providers, and stakeholders from many organizations from across Ontario. The SEEI partner organizations are:

- Canadian Mental Health Association, Ontario
- Centre for Addiction and Mental Health
- Ministry of Health and Long-Term Care
- Ontario Federation of Community Mental Health and Addiction Programs
- Ontario Mental Health Foundation

These provincial organizations, along with representatives from hospital, consumer/survivor and family groups, sat on the Executive Advisory Committee (EAC). Members of the EAC provided the SEEI Coordinating Centre with strategic advice on the research and the overall initiative.

The Ontario Mental Health and Addictions Knowledge Exchange Network (OMHAKEN) was created as part of SEEI. The Network's goal is to create and share research knowledge about services and supports to build a better mental health and addictions system. Existing and new networks have been linked to OMHAKEN, resulting in a broad network of mental health and addictions stakeholders from across the province.

OMHAKEN has provided researchers and research stakeholders with opportunities to connect, share and discuss interim findings. It has also provided the researchers with feedback and context to help them understand and frame their findings. While SEEI was the initial impetus for the creation of OMHAKEN, the network will continue to foster interaction between mental health and addiction researchers and research stakeholders across Ontario, beyond the release and dissemination of this report.

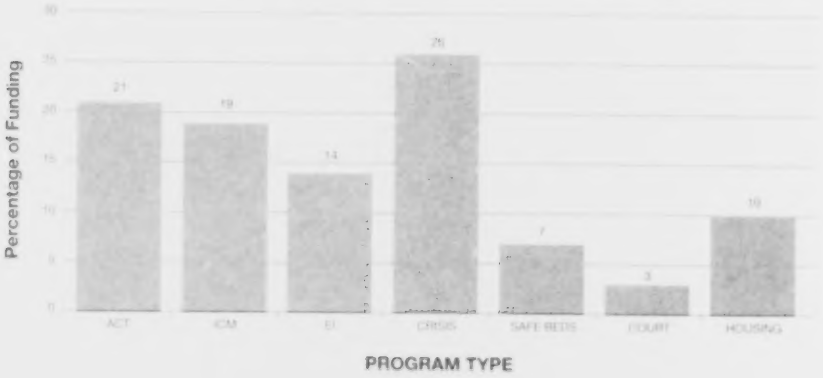
2. Where the New Investments Went

Overall, $167 million new dollars were invested in Ontario's community mental health system.

Graph 1 shows that community mental health programs received varying proportions of the new investments. Crisis programs received 26% of the new funds; court support programs received 3%. For a separate breakdown of Accord and Services Enhancement funding, please refer to Appendix 3. For a description of the different programs funded, please see Appendix 4.

While the actual increases in per capita funding ranged from between $13 and $20 for most of the LHINs, all LHINs did not receive the same proportionate increase through the Accord and Service Enhancement initiatives. Instead, enhancements were designed, in part, to address previously existing funding inequities at the LHIN level.

Graph 1: Combined ACCORD and Services Enhancement Spending by Program Type, 2004 - 2005 to 2007 - 2008 (% of total allocated funding)[2]

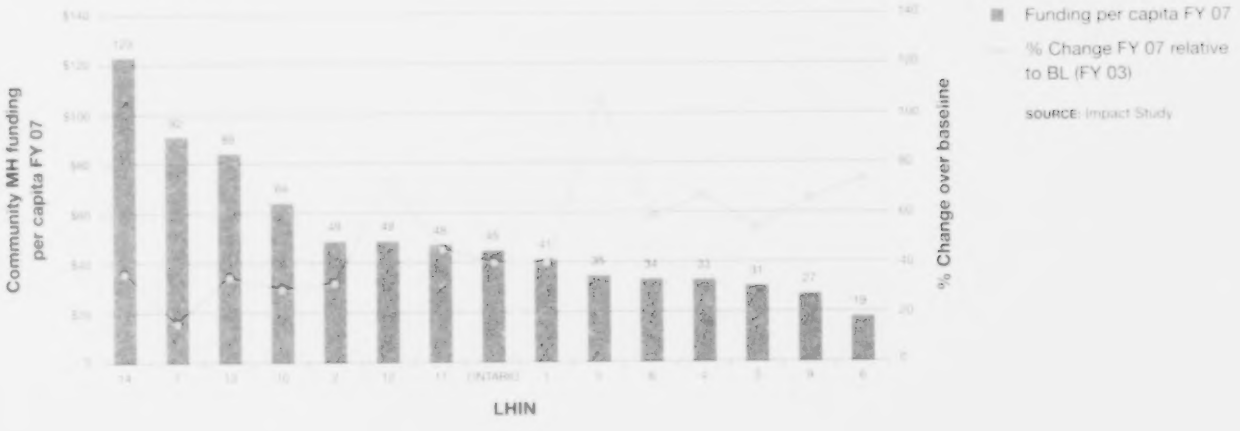


SOURCE: Michael Barker, Ministry of Health and Long-term Care, March 2007, "Funding overview for LHINs: MBarker Mar 1"

2 Program acronyms and names refer to the following: ACT: Assertive Community Treatment team; ICM: intensive case management; EI: early intervention; Crisis: crisis programs; Safe beds: safe beds; Court: court support programs; and housing: supportive housing. These same acronyms are used in Appendix 3.

Graph 2 highlights the relationship between per capita funding for each LHIN, after all the enhancements had been assigned, and percentage change from the baseline.

Graph 2: Association between per capita community mental health funding (FY 2007) and % change from baseline (FY 2003) [3]


Community MH funding per capita FY 07
% Change over baseline
LHIN
ONTARIO
Funding per capita FY 07
% Change FY 07 relative to BL (FY 03)
SOURCE: Impact Study

The graph shows there is still a large variation in the per capita LHIN funding levels across Ontario, ranging from a high of $123 per capita in north-western Ontario (LHIN 14) to a low of $19 in Mississauga Halton (LHIN 6). This may reflect, in part, the reality that the number of community mental health agencies and services available locally varies widely across Ontario.

3 This graph includes all community mental health and addiction program funding from the LHINs or MOHLTC, referred to as Fund Type Two. Funding for community services from hospital global budgets, referred to as Fund Type One, is not included.

3.

Initial Expectations

Stakeholders began this evaluation with a number of expectations, both explicit and implicit, about what the initiative would find:

- With the expansion and improved delivery of community mental health services, there would be a decrease in emergency room visits and hospital stays.
- The new money, while for the most part targeting specific programs and services, would encourage better coordination and integration at the system level.
- A more equitable distribution of new funds across the province would help to address previously existing imbalances in per capita funding across the LHIN's and help contribute to more equitable access to services.
- The new money would provide increased access, better experiences, and better outcomes for families and clients.
- Inappropriate pressures on the jail system, police, courts and forensic in-patient beds would be eased by the infusion of new money.

While some of these initial expectations were supported by the research, others were somewhat simplistic and require re-examination in light of what was discovered.
See page 35.

4.

Approach Taken to Evaluate the System Enhancements

Given the range and scope of the enhancements, the evaluation was designed to be multi-faceted and approach the research through a number of different lenses

The SEEI was made up of nine studies. Two of the nine studies, housed in the HSRCU, were longer in duration and began earlier: (1) the Impact Study evaluated the effects of additional funds at a province-wide, system level using administrative data, and (2) the Matryoshka Study looked at early intervention and court support programs in seven locations across the province by collecting primary data. Seven other studies were funded through a subsequent call for proposals and were located at research institutions across the province. The nine SEEI studies and the scope of their research provided both an in-depth and broad understanding of the impact of the provincial government's new investments, by looking at different system levels and covering a range of urban and rural locations in the province. The studies are outlined in Table 1, with more detailed description provided in Appendix 1.

Table 1: Overview of Studies

The Impact Study	Province-wide, impact on emergency services including police and hospital emergency rooms	A
Assertive Community Treatment Fidelity and Evaluation Study	Province-wide, ACT programs	B
Do Clients Receive More Appropriate Care and Use Fewer Hospital Resources Now That the Community Mental Health System is Enhanced?	Regional community mental health system, Southeastern Ontario	C
Waterloo Wellington Crisis System Evaluation: Understanding the Impact of Enhanced Programs and Coordination	Regional crisis system, Waterloo Wellington	D
Review of Mobile Crisis Services	Three crisis services, Chatham-Kent, Haldimand-Norfolk, and Hamilton	E
An Evaluation of an Integrated Crisis-Case Management Service	Integrated crisis-case management service, Kingston	F
The Matryoshka Study, court support programs	Seven program sites, different locations across Ontario	G
An Evaluation of the Implementation and Outcomes of the CMHA Ottawa Court Outreach Program	One program site, Ottawa	H
The Matryoshka Study, early intervention programs	Seven program sites, different locations across Ontario	I
An Evaluation of Community Based Discharge Planning	One program site, Sarnia-Lambton	J

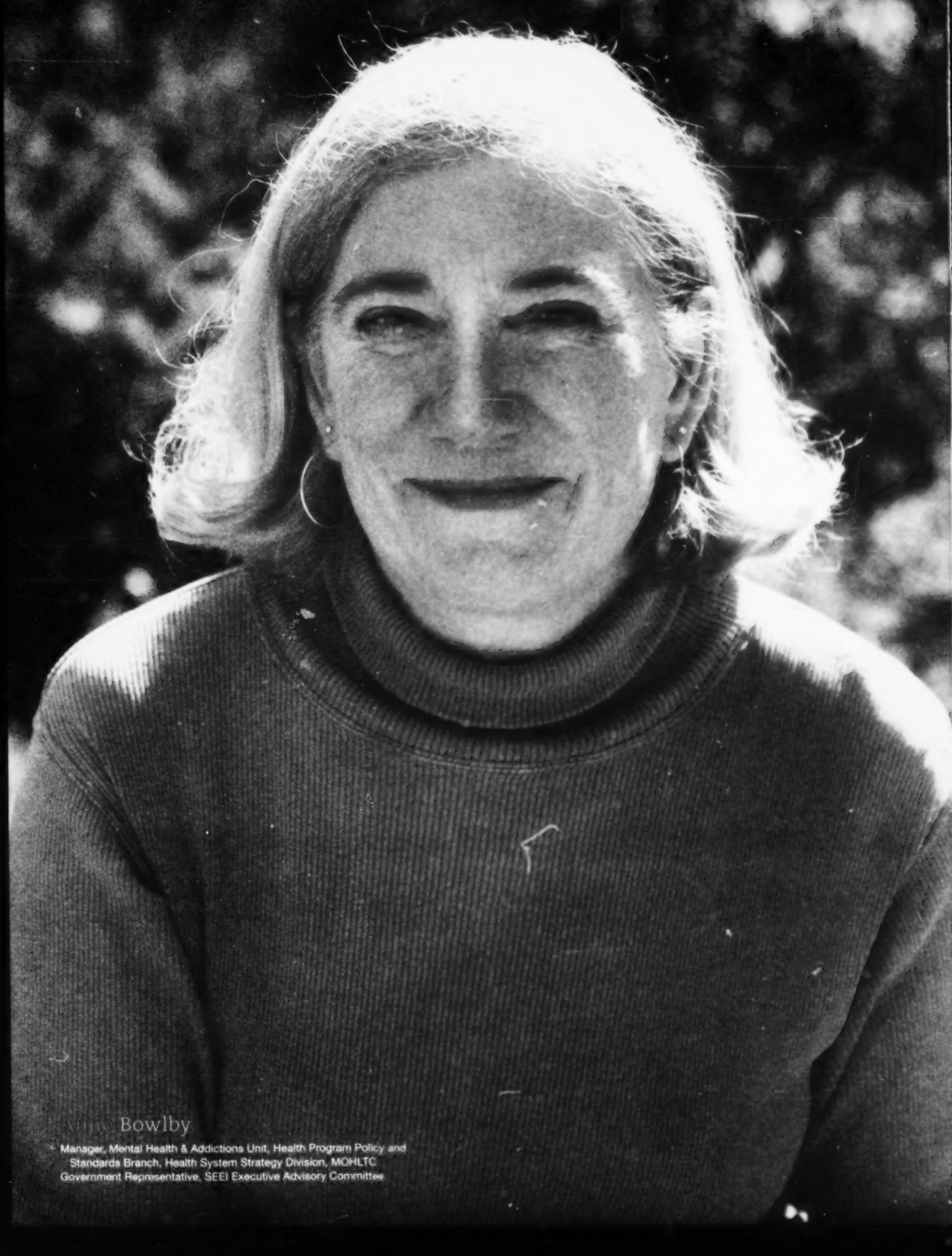
NOTE. The main messages section of the report references individual studies with a corresponding letter, as indicated in the table.

The map of Ontario illustrates where the nine studies were located.

- Program-level study
- Program-level study across a county
- LHIN-wide study

The SEEI studied a broad sample of the programs or systems targeted by the new funding. Over 100 mental health organizations participated in the study in different ways, roughly one-third of the mental health organizations in the province. However, the findings discussed in the main messages section may not necessarily represent the experiences of all programs and systems in the province.

Ottawa
Kingston
Peterborough
Thunder Bay



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Government Representative, SEEI Executive Advisory Committee

5.

Main Messages

This section of the report discusses the main messages that have emerged from SEEL and uses examples from the nine studies to demonstrate the meaning of each message. For further detail about any of the studies, please refer to the table in Appendix 1 and the individual research reports available online, at: www.ehealthontario.ca under the Mental Health and Addictions portal.

More people now have access to more appropriate community mental health services:
There has been a substantial increase in the numbers of people now receiving community mental health services. Table 2 illustrates that some programs were able to double the number of people served.

Table 2: Number of People Accessing Services By Study [4]

7 Early Intervention[1]	161	370
7 Court Support[2]	350	842
1 Crisis[3]	108	216
Kingston community mental health system[4]	3,163	3,537

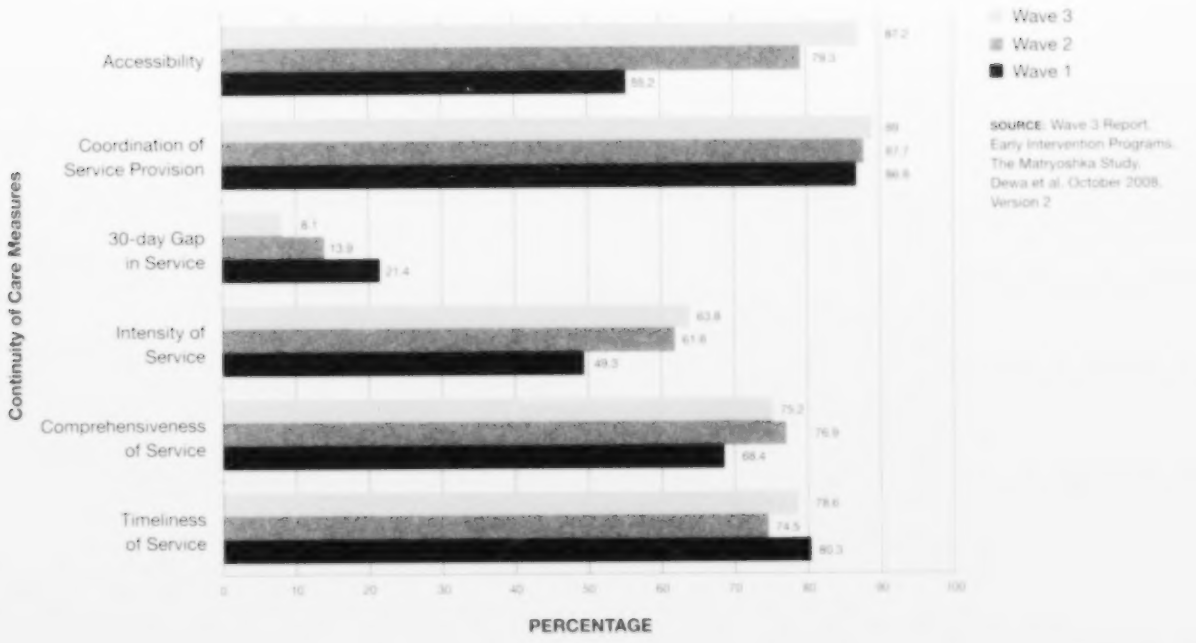
In addition to serving more people, there was also evidence in the early intervention programs and at a regional system-level that an increased number of clients were matched with the level of care they require.[5,6] In turn, fewer regional community mental health clients received a level of care that was less than recommended.[5]

Programs are reaching people earlier:
Early intervention programs are serving clients at an earlier stage in their illness by reaching proportionately greater numbers of young people.[1]

4 The table shows data from three different studies: changes in access from Year 1 to Year 3 in Study G/I, changes in access from November 2004 – October 2005 to March 2006 – February 2007 in Study F, and changes in access from 2001 to 2006 in Study C.

Clients are experiencing better continuity of care:
Graph 3 shows that clients in early intervention programs experienced enhanced continuity of care in the services they received, through for example increased access, comprehensiveness and intensity of service.[5] Waterloo Wellington's regional crisis system demonstrated alignment with several best practices in continuity of care, especially with coordination and access.[D-1]

Graph 3: Continuity of Care Measures for Early Intervention Programs: 2005 to 2007 N = 161 – 370 (I)



SOURCE: Wave 3 Report, Early Intervention Programs, The Matryoshka Study, Dewa et al. October 2008, Version 2

5 Appendix 5 outlines how Studies G/I and D defined "continuity of care."

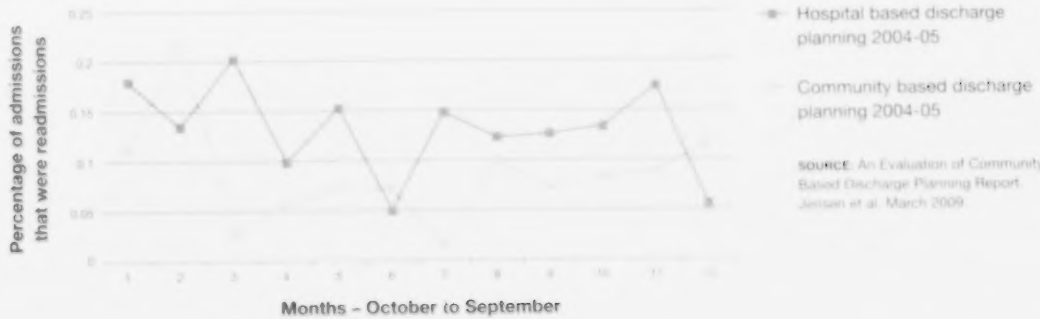
"Yeah, I haven't been to the hospital since I started with the program. Yeah, it definitely helps because we talk about some of the ways to avoid relapse..."

Outcomes for clients have improved:
Clients experienced a range of positive outcomes in the newly-enhanced programs. Not only were individuals in Ottawa's court support program more likely to be able to live independently and in the community, client rates of homelessness and the severity of their symptoms were reduced.[4] Individuals were more likely to exit the redesigned crisis service in Kingston in a way which indicated they had resolved their problems.[5] Reliance on hospital resources decreased in certain programs: early intervention clients had lower relapse rates in their use of hospital and emergency room services,[6] while court support clients experienced an overall reduction in their use of hospital resources.[7]

New funding has been used to innovate and develop better program models:
A crisis service integrated a crisis outreach mobile team with a newly developed transitional case management service, improving the reach of the new model and serving clients within a length of time seen as more appropriate for a crisis service. With the new model, clients were more likely to have been referred by a community organization or through their own personal networks instead of by a hospital.[8]

By situating a discharge planning service in a community-based agency that also provides housing advocacy, case management and other mental health services, clients were provided with direct access to the follow-up services they need following their discharge from hospital. In addition, hospital readmission rates in the first month and overall following discharge decreased, after the change in location of the discharge planning service.[9]

Graph 4: Readmission Rates to a Hospital Psychiatric Unit Within 30 Days Following Discharge, Before and After the Change in Discharge Service Location, 2004-05 and 2005-06. 2004-05 N = 555; 2005-06 N = 537 (J)[6]



6 This chart represents discharges of all individuals who used the Bluewater Health hospital psychiatric unit in 2004 – 2005 (N = 555) and 2005 – 2006 (N = 537), the year before and after the change in service location. The sample of individuals who were included in the study were recruited in the second year after the change took place.

Funds targeted at the system level lead to system level impact:
System change and integration happened in the community mental health system when investments were targeted at system-level coordination and integration activities.

The Waterloo Wellington crisis system, which received targeted investments to create LHIN-wide coordination positions and a system-level network, made significant progress towards system integration. Several inter-agency protocols were developed on crisis service delivery and supports, referrals between different agencies reflected an increased awareness of available crisis services, and the Waterloo Wellington Dufferin Regional Crisis Committee was established and continues to meet.[D]

Enhancing bridges between the community mental health and justice sectors has shown mixed results:
At a provincial, system-wide level, there was an increase in mental health related contacts with the police and apprehensions under the Mental Health Act. Possible explanations include better reporting, increased recognition, and/or increased demand.[A] There was some variation across regions. Over a two and a half year period, the number of mental health related calls made to the police in the Waterloo Wellington area increased. Yet over the same time period, the number of apprehensions that police made using the Mental Health Act decreased, indicating that the crisis system may be using other, less restrictive ways of getting people the care they need.[D]

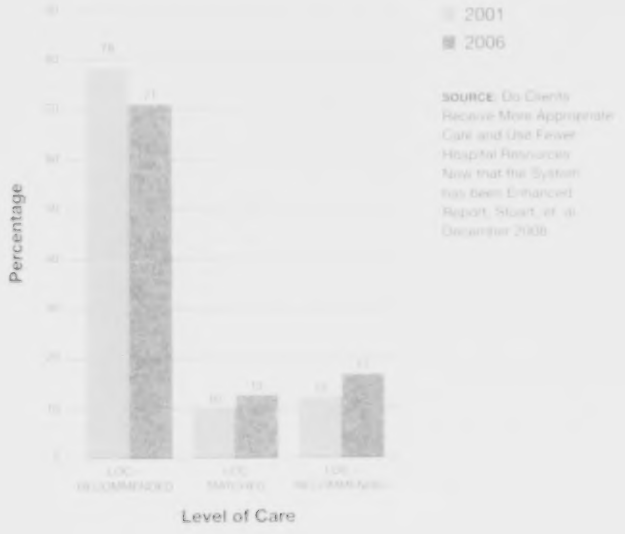
There were frequent partnerships between police and mental health services for training and on-site response across the province, and the majority of services reported increased participation in area mental health initiatives.[A]

The enhancement of court support programs situated inside the criminal justice system has helped to facilitate some improvements inside that system. While a significant proportion of court support clients were not transferred out of the court system, they did start receiving community mental health services.[G] By working with clients in the court support program, court backlogs were reduced and the functioning of the court system improved. Courts were able to use their time more efficiently as court support workers guided their clients through the court system.[H] Court support workers served a boundary spanning role, by providing information and support to individuals other than clients, including members of the justice sector, potential clients and their families, and other community agencies and providers.[G, H]

While more people have been appropriately served as a result of the enhancements, research findings have highlighted the sectors' limited resources to serve all those in need.

Limited capacity to serve all those in need:
Graph 5 shows that while under-servicing of clients declined in Kingston's community mental health system, it remained a problem. Under-servicing was especially problematic for clients recommended for the intensive or daily community support level of care.[C] Although the Ottawa court outreach program was able to improve its reach, serving between 90 – 120 clients, this capacity is still small compared with the thousands of people who go through the city's court system each year.[D]

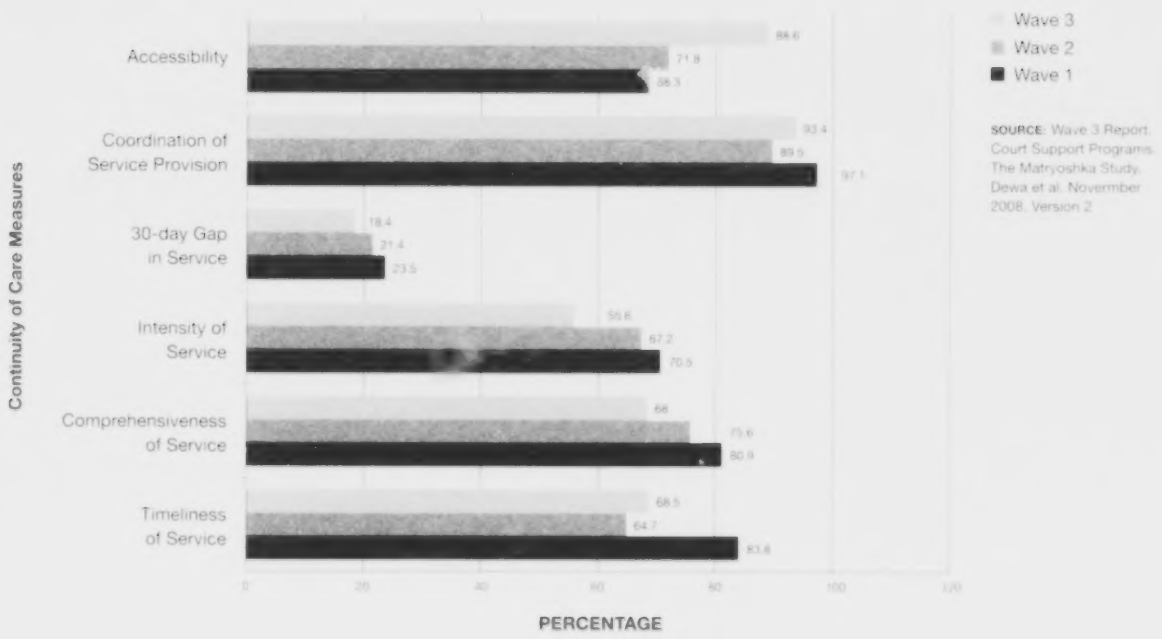
Graph 5: Changes in Level of Care (LOC) Match Among Clients Recommended for Intensive Community Care, Southeastern Ontario's Community Mental Health System, 2001 to 2006 N = 3,163 – 3,537 (C)



SOURCE: Do Clients Receive More Appropriate Care and Use Fewer Hospital Resources Now that the System has been Enhanced? Report, Stuart, et. al. December 2008.

Enhancements to one part of the system create additional need in other parts of the system:
While the numbers of clients able to access court support programs increased significantly, there has not been a corresponding increase in related services that clients require such as intensive case management and psychiatry. With limited ability to make appropriate referrals in a timely fashion, Graph 6 shows that clients' perceptions of continuity of care decreased over the three-year study period on measures such as timeliness of service and 30-day gap in service.[5]

Graph 6: Continuity of Care Measures for Court Support Programs, Waves 1, 2 and 3, 2005 to 2007 N = 350 – 842 (G)



SOURCE: Wave 3 Report. Court Support Programs. The Matryoshka Study. Dewa et al. November 2008. Version 2.

Limited access to broader supports and services: Having access to a broader range of supports and services will help clients move out of poverty and isolation, and support their ability to fully engage as citizens.

Clients experienced a lack of treatment options and support resources, particularly in the areas of housing, intensive support and vocational training.[4] Clients living in rural areas who experienced a crisis faced challenges with transportation, which sometimes created safety issues.[5] Clients are still confronted with extreme poverty, unemployment and a lack of education, making it difficult to reduce relapse rates. For example, the majority of court support clients had annual incomes lower than $11,000, and most early intervention clients had no post-secondary education.[6]

Further, at the regional level, one of the highest areas of unmet need for clients was a lack of access to dental, social and vocational services.[7] Clients were more likely to be hospitalized if they found it difficult to look after their own basic self care and, for a variety of psycho-social reasons, had limited access to needed social and financial resources. This is an indication that those who had a higher chance of being hospitalized were most in need and lacked broader social supports.[8]

"A major problem with me is oral health... I have three teeth that two of them I extracted myself because I couldn't afford to get them out... ...if I didn't have this problem, I'd probably be trying to get a line of work in customer service or sales..."

Varied impacts on hospital use:[7]

At the provincial and LHIN-levels, demand on hospital emergency rooms by people experiencing mental health challenges increased. However, the demand did not change in the same way across user groups.[8] Graph 7 shows that the numbers of new[9] clients decreased their use of emergency room services, whereas use by other groups increased.[8]

Graph 7: Total Emergency Room Psychiatric Visits by Client User Group 2002 – 2007 (A)

*Serious Mental Illness

SOURCE: Impact Study

7 The Impact Study reported results for three indicators of hospitalization in the mid term report, comparing baseline and 2005-06. Due to implementation of a new hospital reporting system in October 2005, results for 2007-08 could not be compared to previous years. As a result, plans for continued monitoring of hospitalization trends could not be carried out.

8 Even when use is adjusted for population growth, the trends hold.

9 New users had no contact for mental health reasons with hospital inpatient, hospital emergency rooms and fee-for-service providers in the previous two years.

In contrast, Graph 8 shows a decrease in 30-day returns to emergency rooms.[A] This reduction was most pronounced amongst individuals aged 16 to 34, the group classified as younger.

Graph 8: Change in 30-Day Return Rates to Emergency Departments After Previous Visit, by Client Group, 2002 to 2007 (A)

While system level changes are influenced by many factors, the decreased numbers of new clients using emergency rooms and reduction in early return rates to emergency departments during the period of enhancements to the community mental health system is encouraging.

At the regional level, while the majority of clients studied in the Kingston community mental health system study did not use hospital resources, those who did use these services increased their use from 2001 to 2006. The number of contacts with emergency departments increased, and the number of days of hospital care per person doubled.[C]

At the program level however, there was some evidence of decreased reliance on hospital resources for court support and early intervention clients.[G1]

System fixes:

During the four-year evaluation, a number of system fixes were identified that, if implemented, could help to address some of the system challenges found.

- Establish regional and/or provincial rosters of available psychiatric beds to provide police and crisis workers with information about where psychiatric beds are available. This would help to reduce extensive waiting times in hospital emergency rooms for police, crisis workers and clients.[E]
- Ensure that crisis service users are able to reach a real person on a crisis line at all times, even during periods of high demand. Clients were frustrated if their call went to an answering service or they heard a busy signal.[E, F] While crisis service capacity was increased through the enhancement funding, this system fix highlights the reality that most crisis services are not funded to provide 24-hour coverage and that service delivery is vulnerable during times of peak demand.
- Establish "warm lines," possibly peer-run, which would offer individuals the possibility of having a place to call, vent and obtain the support they need even if they don't feel like they're experiencing a full-fledged crisis.[E, F]
- Crisis programs should incorporate mobile outreach, particularly in rural areas where client access to safe transportation is not always available.[E]
- If the police become involved in a mental health crisis, ensure that this does not result in clients automatically developing an official record of their interaction with police, affecting future opportunities to volunteer or obtain employment.
- Provision of follow-up technical assistance and monitoring would help to support and address challenges identified in different parts of the system. For example, despite the additional funding provided to ACT programs, the average ACT teams' caseload was 6:1, lower than the recommended ratio of 8-10:1. While some ACT teams function at full capacity, others operate below the standard caseload ratio, providing an opportunity to monitor and compare the different caseload ratios of various teams.[B] Also, it was found that while progress was made towards a recovery-orientation in ACT programs,[B] in the Waterloo Wellington regional crisis system,[D] and in staff attitudes,[H] more work needs to be done before the community mental health system fully reflects a recovery orientation. Technical assistance and monitoring could play a valuable role in supporting this development.

"When the [crisis] line is busy, when they say 'can I put you on hold?' ... left me high and dry..."

Mixed experiences with initiating the new investments:
The initial planning, coordination and funding allocation process for applying system enhancements to Ontario's community mental health sector affected how efficiently and quickly the funds could be used to start up or enhance programs. Evidence showed that the field experienced the process in both positive and negative ways.

In the first round of funding, a clearly articulated funding recommendation process was lacking, and there was little advance notice that funds were coming which affected the extent to which planning could take place. The process improved in subsequent funding disbursements with local decision-makers working together to make recommendations to government about the distribution of funds. While the promise of new investments in the community mental health sector was invigorating to many, short timelines did not always allow for a full consultation and decision-making process, and made it difficult to hire qualified staff and develop the necessary infrastructure in time to build enhanced programs and services. Challenges emerged when funds became available too fast or not fast enough. In addition, the field found that Ministry priorities were not always well communicated or well understood, and did not always coincide with local priorities.[G4]

System enhancement takes time:
Newly-enhanced programs and systems were still developing and maturing as the SEEI took place, indicating that study findings likely do not reflect the full capacity of enhanced services and systems.[C D F] In addition, the ongoing development and maturation of programs and systems posed a challenge for researchers as they were evaluating a "moving target".[D]

Hiring and retaining the right staff is a challenge:
Programs experienced difficulties in adequately staffing their programs.[B E] ACT teams found it difficult to recruit and retain psychiatrists, substance abuse specialists trained in concurrent disorders, vocational specialists, and peer support workers.[E] Crisis programs noted that having experienced and trained staff in handling the full range of psychiatric crises is fundamental to positive outcomes for clients. In urban areas where there is higher volume, multi-disciplinary teams can address the range of crises. In rural areas however, an individual crisis worker must have the skills necessary to address the variety of crises that they will be faced with.[E]

Studies found that distinct skills and training are required for specific positions and roles. Police require extensive training and education in mental health and addictions.[E] The new transitional case management program needed staff with skills which are distinct from those of a traditional crisis worker and case manager in order to make the program as effective as possible.[F]

The MOHLTC's decision to evaluate the impact of new funds while they were being applied has paid off. Research findings have been shared with practitioners, system planners and other stakeholders at various points in the evaluation process, providing the evidence-base for policy, program and system improvements to be made during the four-year initiative. The presence of a knowledge exchange network and an EAC composed of a broad range of stakeholders from the project's start has facilitated this process.

The EAC helped define the research studies at the beginning, and members have provided valuable perspective on the interpretation of study results. Interim study findings have been shared with most of the newly established LHINs and their mental health and addiction planning tables, providing them with accurate timely information for use in decision-making and planning. In turn, feedback from local stakeholders has helped researchers to refine performance indicators and study areas and provided them with a better understanding of local contexts and health systems.[A] At the individual program level, feedback from the ongoing evaluation has allowed for improvements to be made to planning and service delivery.[F] SEEI data have been shared at different stages during the four-year evaluation with all levels within the MOHLTC and with other Ministries, and has been used for planning and reporting purposes.

Different initiatives are in place to move forward with the results of the nine studies. More than 450 diverse stakeholders have already taken part in various regional events, to learn about study results and to discuss ways in which those results can be practically applied at the policy and program levels.

An individual organization found the evaluation process so useful, they are now considering development of a systematic evaluation process for the entire organization.[F] ACT teams and stakeholders of ACT are interested in developing strategic plans to further address particular challenges identified in the study, for example, around supported employment, integrated substance abuse treatment, and recruitment and retention of specific kinds of staff.[B]

"I think that... for us locally as an agency to be able to participate in this kind of research I think is extraordinarily helpful... I think that the research project for us, in terms of being able to analyze the program from a systemic point of view with clear, hard data has been very, very helpful."

Nancy Chau

Research Coordinator, Health Systems
Research and Consulting Unit, CAMH
Research Coordinator, Study G/I

6. Future Research

SEEI principal investigators identified a number of areas that require further research:

Continued program and system monitoring:
Principal investigators pinpointed the need for continued monitoring at the program and system levels. ACT teams would benefit from continued monitoring and implementation support.[B] Community mental health programs in Southeastern Ontario, which had not yet fully operationalized all enhancements during the evaluation, would also gain from continued monitoring and a replication of the same study at a later date.[C]

At the system level, ongoing monitoring of emergency services use, for example hospital and police services, by people with mental health issues, using the methods and tools developed by SEEI, would be important since the current volatile economic environment in Ontario may affect both service availability and need. Some of the measures are based on automatically collected data and would be cost-effective to follow over time.[A]

Outcome evaluations:
Future evaluations focused on outcomes would provide useful data. This type of evaluation of the Waterloo Wellington crisis system would provide valuable information as the system continues to mature.[D] Research on court support programs should continue to examine a wide range of outcomes that look at housing, employment and income, as well as service use, change in legal status and relapse rates. The research should follow clients for a period of time after they leave a program to better understand the sustainability of outcomes.[G, H] Studies should investigate the link between the effectiveness of early intervention programs and long-term outcomes such as completion of education and employment.[I]

More broadly, studies should incorporate an economic analysis, looking at system and societal costs and how these relate to outcomes such as ability to remain in the community and employment.[J]

Program standards and policy:
Investigators pointed to the need to identify structures and processes that can serve as service standards for the implementation of court support programs.[G, H] Further, it would be useful to look at how policy and basic provincial standards can be designed to encourage innovation and ensure that local needs are identified and met.[G, I]

Use more rigorous study designs:
Investigators suggested ways in which follow-up research could be more rigorous. Future studies of court support programs should include randomized controlled trials so that client outcomes can be more conclusively linked to participation in programs. Studies should also include larger numbers of clients so that changes can be measured more precisely.[H] Future evaluations of community based discharge planning should include baseline data and a comparison group to improve confidence in study results.[J]

Data quality and consistency:
Researchers found there was variability in the type and quality of data collected at the system and program levels, sometimes limiting the extent to which investigators could draw conclusions. A number of different solutions were proposed:

- Develop and adopt common minimum data sets for crisis services.[E]
- Identify system-level performance indicators and how to measure them reliably.[D]
- Evaluate outcomes using data collected by researchers, instead of relying on program administrative databases.[H]

- Provide unique identifiers to track clients as they progress through the system, particularly to track those who leave specific types of programs.[B]
- Develop minimal police data sets for monitoring contacts and how people experiencing mental health challenges are dealt with.[A]
- Continue investigating and monitoring the quality of new inpatient data available through the Ontario Mental Health Reporting System (OMHRS) so that the accuracy of trends over time can be evaluated.[A]

Conceptual and methodological challenges:
The Waterloo Wellington regional crisis system study was faced with the conceptual and methodological challenge of how to incorporate and measure recovery principles at the system level. The community mental health system will continue to wrestle with these issues as the system shifts towards a recovery focus.[D]

Follow-up research:
Investigators identified other areas in need of follow-up research.

Future studies of court support programs should document the community context in which they operate, and describe service system inadequacies that make it difficult to refer clients once they are ready to exit from a program.[H] Related to this is the need to examine discrimination against clients with involvement in the legal system and how to address this challenge to ensure access to necessary follow-up services.[G]

An in-depth look at the processes by which ACT treatment is provided would help to improve understanding and enhance effectiveness of ACT. A case study approach could contrast teams that are the most effective according to current measures with teams that appear the least effective.[B]

Replication and extension of the community-based discharge planning study could test the model in other larger urban settings or in areas where there are multiple hospitals and community agencies.[J] Studies of crisis services should also identify different service needs according to whether the program is located in rural or urban settings.[E]

The possibility of replicating the study of Southeastern Ontario's community mental health system in other parts of the province that also did the Community Comprehensive Assessment Projects (CAP) should be explored, along with the feasibility of re-creating unique identifiers so that individuals can be followed as they move through the system. This would provide useful comparative data across different regions of the province.[C]

There is a need to identify and study program models that best serve people experiencing moderate levels of mental illness as there are few services which focus on their needs.[F]

Continued work is required to develop measures of integration and appropriate reporting units in local service areas.[A]

For the delivery of services for clients served by several sectors, future studies should explore the most effective mechanisms for promoting inter-ministerial collaboration.[G]

As a general guide, future studies should always include consumer/survivors on the research team as they bring insights from the perspective of receiving services.[J]

Len Wall

Family Representative
SEEI Executive Advisory Committee

7.

Closing

Findings from the SEEI clearly show that the targeted investments in evidence-based practice are moving the community mental health system in the right direction. Reflecting back on the initial expectations, the research has demonstrated the following:

- Strategic investments made at the program level have paid off at the program level. Enhancement funding has provided programs with the capacity to reach more people at the right time, at the right place, and in the right way, helping to make a positive difference in the lives of clients and their families, and illustrating that strategic investments in evidence-based practice have paid off. However, investments have not helped those still unable to access the services they need, due to the still limited capacity of the system to serve everyone in need.
- Investigators found that changing a system can take longer than expected. One of the initial expectations of SEEI was that with enhanced services at the community mental health level, demand on emergency rooms would decrease. Yet, findings point to emergency room rate increases across the province. However, there were other, encouraging signs suggesting that system enhancements are making a difference at the hospital level. New users of the mental health system showed a decrease in their use of emergency rooms, and 30-day return rates to emergency rooms reduced across the province. There was also evidence that reliance on hospitals decreased in particular programs. Ongoing monitoring of emergency room use will provide useful data as system enhancements continue to show their full impact.
- Findings indicated that system integration happened where it was specifically targeted with funding, not, as initially expected, as a spin-off resulting from new funding for specific programs and services.
- Progress has been made in addressing per capita funding differences across the LHINs. Differences, however, remain considerable. While funding levels should reflect the level of need and geographic differences by LHIN, the variation continues to affect the extent to which equitable services can be provided across the province.
- Pressures on police appear to have increased, with the finding that mental health related contacts and apprehensions by officers under the Mental Health Act (MHA) went up at the provincial level, with some variation across regions. Possible explanations for the rise include not only increased demand, but also better reporting and recognition.
- Court support programs and workers played a "boundary spanning" role, and the enhancement of court support programs situated inside the criminal justice system has helped to facilitate some limited improvements inside that system. These improvements are limited due to the narrow reach of court support programs in relation to the population in need of service.

Continued monitoring and evaluation of the enhancements, and the system more generally, will give us more information about the effects of the enhancements, as many take years to materialize.

Studies show that the enhancements have made a significant difference in a broad variety of ways, most importantly in the lives of clients and their families. The system is indeed moving in the right direction.

Dr. Paula Goering

Professor, University of Toronto
Co-Section Head, Health Systems Research
and Consulting Unit, CAMH
CIHR/CHSRF Health Services Chair
SEEI Principal Investigator

8.

We hope that reading this report has whetted your appetite for more information about the methods and findings from the SEEI studies that have been described. You can relieve your hunger by going to the web to down load the individual study reports and published articles or by arranging or attending a presentation of the findings in your local area or at the next conference that you are attending. Our intention is that this not be a "final" report, but rather another installment in the ongoing dialogue about what we can do to enhance the community mental health system's ability to meet the needs of all those who are living with mental illness.

The dialogue about this issue is alive and well at this time in the evolution of mental health reform. With provincial and national discussions about future strategy currently underway, there is a great deal of interest and attention to the questions of what we have learned and how we can do a better job in the future. There are several ways in which these studies can inform the answers to such questions. Our findings can help to point out where there is a need for further investments, e.g. in court support services and in the parts of the system that they need to refer their clients to. They can also underline the need to pay attention to making sure that current investments are working as well as they can, e.g. addressing the continued low client worker ratios within the Assertive Community Treatment teams. There is strong support for inter-ministerial responses that bridge the artificial boundaries at the front line level between providers, e.g. police and mental health crisis workers. The need to revamp our training and human resource strategies so that they equip us with the right kinds of staff with the right skills and knowledge (e.g. concurrent disorders) is underlined by the findings of several studies. Although a lot of progress is evident with regard to implementing a recovery oriented system of care, there are many reminders from consumers of services that we are not there yet. Finding ways to further involve consumers in their care and in the delivery of services and supports is an ongoing challenge.

No matter how well informed current planning is by evidence, there can be no guarantee that implementation of policy and plans will achieve intended results. Without ongoing monitoring and evaluation activities there is always the danger that investments will fail or that we will miss the longer term benefits of current investments. One of the most important impacts of the SEEI and the Community Mental Health Evaluation Initiative (CMHEI)[10] projects is the creation of a community and a culture of evaluation that is well established and eager to continue learning. The research/stakeholder partnerships that have been built and the students and staff that have been trained are a resource for the future. Taking full advantage of this legacy will take some effort. OMHAKEN can help to sustain the interactions that bring the worlds of research and service together. Addressing the serious gaps in our ongoing data collection infrastructure would make quality improvement easier and less costly. Expanding the ongoing capacity for standards development and assistance with the implementation of best practices will keep alive the culture of inquiry and of reflective practice that agencies seem to appreciate so much.

In the end it is also important to remember that formal services and systems are only a part of the picture. As our results have shown, the larger society in which the community mental health system is located has a profound influence upon the lives of those who seek help. Poverty, discrimination, homelessness, and unemployment can prevent or undo positive effects of high quality and accessible services and supports. We must all accept responsibility for also addressing these issues, so that those with mental illness are truly included as full citizens along side with everyone else.

Dr. Paula Goering
PRINCIPAL INVESTIGATOR
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10 The CMHEI was a multi-site evaluation of community mental health programs in Canada, planned and conducted with the involvement of a broad range of players, including government, community providers, family and consumers.

SEEI RESEARCH STUDY	MAIN FINDINGS	PRINCIPAL INVESTIGATORS, PARTNER ORGANIZATIONS AND CONTACT INFORMATION
PROJECT REFERENCE IN REPORT: A This study monitored the impact of new funding on: the composition and capacity of the community mental health system; system organization and integration; and changes in the number of people with mental illness using hospital and police services. The study has relied mainly on existing provincial health administrative data. *Further findings from the Impact Study, including the Crisis Program survey, are forthcoming.*	Progress has been made in addressing per capita funding differences by LHIN, but funding variation by LHIN remains substantial. Demand on hospital ER services by people with mental health challenges increased. Almost all of the LHINs showed a decrease in early returns to ER. Police services reported an increase in mental health related contacts and apprehensions under the Mental Health Act. Possible explanations include: better reporting, increased recognition, or increased demand. There were frequent partnerships between police and mental health services for training and on-site response across the province. A considerable amount of activity has taken place in this area since 2005.	**PRINCIPAL INVESTIGATORS:** Drs. Janet Durbin and Elizabeth Lin, HSRCU, CAMH, and the Department of Psychiatry, University of Toronto **EMAILS:** janet_durbin@camh.net elizabeth_lin@camh.net **WEBSITES:** www.camh.net/Research www.utpsychiatry.ca
PROJECT REFERENCE IN REPORT: B This study of the ACT Program across Ontario assessed the degree to which high fidelity to the ACT model, and incorporating a recovery focus influences client outcomes.	Overall, ACT Teams are providing high quality, client-centered services aligned with evidence-based ACT standards. Average ACT caseloads are lower than the ACT model specifies, at 6:1 (client: provider). Recovery-oriented service delivery appears to be occurring. There are challenges in staff recruitment and continuity, especially in psychiatry, vocational supports and substance abuse specialists, and peer providers. There are limits to the tools currently available to evaluate ACT.	**PRINCIPAL INVESTIGATORS:** Dr. Lindsey George, St. Joseph's Healthcare and Department of Psychiatry and Behavioural Neurosciences, McMaster University Dr. Sean Kidd, St. Joseph's Healthcare and Department of Psychiatry and Behavioural Neurosciences, McMaster University and Yale Department of Psychiatry **EMAILS:** lgeorge@stjosham.on.ca skidd@stjoes.ca **WEBSITE:** www.psychologytraining.ca/faculty **PARTNER ORGANIZATION:** Technical Advisory Panel for ACT (MOHLTC)

SEEI RESEARCH STUDY	MAIN FINDINGS	PRINCIPAL INVESTIGATORS, PARTNER ORGANIZATIONS AND CONTACT INFORMATION
PROJECT REFERENCE IN REPORT: C This study evaluated whether the increased community mental health funding: (1) improved the match between service need and service use, and (2) reduced hospital inpatient and emergency use, specifically in the Kingston area community mental health system.	More patients are accessing community care now that additional funding has been received. There is now a better matching of services to client needs. Under-servicing, however, remains a problem, particularly for those clients who need the most intensive community services. Over-servicing is still a challenge for clients who require the least intensive services. Although most community mental-health clients do not use hospital resources, hospital use in the region seemed to be increasing which appears to be unrelated to socio-clinical factors that might predict a higher need for hospital care.	**PRINCIPAL INVESTIGATORS:** Dr. Heather Stuart, Department of Community Health and Epidemiology and Department of Psychiatry, Queen's University Dr. Terry Krupa, School of Rehabilitation Therapy, Queen's University **EMAILS:** heather.stuart@queensu.ca krupat@queensu.ca **WEBSITES:** meds.queensu.ca/ www.rehab.queensu.ca/ **PARTNER ORGANIZATION:** Southeastern Ontario Mental Health Alliance
PROJECT REFERENCE IN REPORT: D This study evaluated the impact of new and enhanced crisis support services on: the quality of services received by people with lived experience, and on crisis system capacity more generally.	Best practices in continuity of care are happening, especially in coordination and access. Recovery principles are beginning to be incorporated, but more needs to be done. More needs to be done to address lengthy hospital ER wait times, and before system enhancements are experienced as beneficial by police and hospital staff.	**PRINCIPAL INVESTIGATORS:** Ms. Eleanor Harder, Crisis System Coordinator, Waterloo Wellington Dufferin Regional Crisis Committee Dr. Joan Nandlal, CAMH and Department of Psychiatry, University of Toronto **EMAILS:** joan_nandlal@camh.net eharder@trellis.on.ca **WEBSITES:** www.utpsychiatry.ca/ www.camh.net **PARTNER ORGANIZATIONS:** Waterloo-Wellington LHIN-Wide Crisis Committee

SEEI RESEARCH STUDY	MAIN FINDINGS	PRINCIPAL INVESTIGATORS, PARTNER ORGANIZATIONS AND CONTACT INFORMATION
PROJECT REFERENCE IN REPORT: **E** This study evaluated and compared three different crisis program models, to better understand the crisis services themselves, and the complexity of issues surrounding interactions between police and people experiencing mental illness. Each program and the communities being served are described in detail.	While all communities valued their crisis services, all identified limitations related to responsiveness during peak periods and transportation concerns. Rural communities were most disadvantaged by transportation issues which at times created safety issues. Consumers in all settings wanted more peer support as part of the crisis services. They discussed the need for "warm lines" as well as "hot lines." Access to beds was a major issue. The lack of access created a bottleneck in emergency rooms, and tied up police as well as crisis workers. Gaps in the continuum of care in each community will be reflected in the nature of and frequency of crises seen. There are human resource challenges in staffing for crisis services.	**PRINCIPAL INVESTIGATOR:** Dr. Cheryl Forchuk, School of Nursing, Faculty of Health Sciences, and the Department of Psychiatry, Schulich School of Medicine & Dentistry, University of Western Ontario **EMAIL:** cforchuk@uwo.ca **WEBSITE:** publish.uwo.ca/~cforchuk **PARTNER ORGANIZATIONS:** Lawson Health Research Institute, COAST Hamilton, St. Joseph's Mountain Health Care Services
PROJECT REFERENCE IN REPORT: **F** This study evaluated an integrated crisis-case management service model redesigned using the new government funds. The study evaluated accessibility to mobile services; appropriateness of and accessibility to follow-up services; and acceptability of the new services to the surrounding community. The study developed a competency profile for the new transitional case manager positions.	The integration of transitional case management and assertive mobile outreach with crisis services has lead to positive changes in crisis service use patterns. Transitional case management is characterized by distinct competencies differentiating the position from both crisis worker and case manager. Crisis service users value crisis services highly but their experiences are influenced by several key tensions. Outreach to the community service network should accompany major changes in crisis programs. Traditional satisfaction surveys provide limited understanding of how clients experience or are helped by crisis services. The model has potential to be relevant and generalizable to other communities.	**PRINCIPAL INVESTIGATORS:** Dr. Terry Krupa, School of Rehabilitation Therapy, Queen's University Dr. Heather Stuart, Department of Community Health and Epidemiology, Department of Psychiatry, Queen's University Alan Mathany, Director of Operations, Frontenac Community Mental Health Services **EMAILS:** krupat@queensu.ca heather.stuart@queensu.ca amathany@fcmhs **WEBSITES:** www.rehab.queensu.ca meds.queensu.ca www.fcmhs.ca **PARTNER ORGANIZATIONS:** Frontenac Community Mental Health Services

SEEI RESEARCH STUDY	MAIN FINDINGS	PRINCIPAL INVESTIGATORS, PARTNER ORGANIZATIONS AND CONTACT INFORMATION
PROJECT REFERENCE IN REPORT: **G** This study looked at Court Support Programs located in seven sites throughout the province, including rural and urban regions. The study explored the effects of the Government's new investments on the continuity of care received by new and ongoing clients of the system in this specialized program.	Increased numbers of new clients are receiving services in the program, and the program is serving its target population. The continuity of care experienced by court support clients decreased over the three year study. Court support clients experienced an overall reduction in their use of hospital resources. Clients are faced with the broader challenges of poverty, unemployment and education. The program provides a wider service to the community beyond their clients.	**PRINCIPAL INVESTIGATOR:** Dr. Carolyn Dewa, HSRCU, CAMH, and the Department of Psychiatry, University of Toronto **EMAIL:** carolyn_dewa@camh.net **WEBSITES:** www.camh.net/Research www.utpsychiatry.ca **PARTNER ORGANIZATIONS:** CMHA Toronto St. Michael's Hospital, Toronto CMHA Windsor CMHA Peterborough CMHA York CMHA Thunder Bay CMHA Hamilton Muskoka Parry Sound Community Mental Health Services The Lynx Early Intervention Psychosis Program, Peterborough
PROJECT REFERENCE IN REPORT: **H** This study evaluated a unique program model of court outreach, where intensive community support is integrated into the legal process. The study assessed the extent to which the program was delivered as planned, and evaluated program outcomes with former court outreach clients.	Clients of the program correspond well with the intended target population. For the most part, the Court Outreach Program is being implemented as planned. The needs of clients in the legal system are greater than program services available. Clients who have finished the program experience better community adaptation, reduced severity of symptoms and less homelessness. System-level outcomes include: reduction in administrative burden, development of associated and needed community services, and assistance with follow-through on court orders	**PRINCIPAL INVESTIGATOR:** Dr. Tim Aubry, School of Psychology, Centre for Research on Educational and Community Services, University of Ottawa **EMAIL:** Tim.Aubry@uOttawa.ca **WEBSITE:** www.iph.uOttawa.ca **PARTNER ORGANIZATIONS:** CMHA, Ottawa

Appendix V: Overview of Nine SEEI Studies

SEEI RESEARCH STUDY	MAIN FINDINGS	PRINCIPAL INVESTIGATORS, PARTNER ORGANIZATIONS AND CONTACT INFORMATION
PROVINCIAL-LEVEL STUDIES		

PROJECT REFERENCE IN REPORT:
I

This study looked at First Episode of Psychosis Programs located in seven sites throughout the province, including rural and urban regions. The study explored the effects of the Government's new investments on the continuity of care received by new and ongoing clients of the system in this specialized program.

Increased numbers of new clients are receiving services in the program, and the program is serving its target population.

Early intervention clients have experienced increased continuity in services received.

Clients of the early intervention programs had lower recidivism rates in their use of hospital and emergency room services.

Clients are faced with the broader challenges of poverty, unemployment and education.

The program provides a wider service to the community beyond their clients.

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CMHA Windsor
CMHA Peterborough
CMHA York
CMHA Thunder Bay
CMHA Hamilton
Muskoka Parry Sound Community Mental Health Services
The Lynx Early Intervention Psychosis Program, Peterborough

SEED RESEARCH STUDY	MAIN FINDINGS	PRINCIPAL INVESTIGATORS, PARTNER ORGANIZATIONS AND CONTACT INFORMATION
PROGRAM LEVEL STUDIES		

PROJECT REFERENCE IN REPORT:
J

This study evaluated a community-based model of discharge planning, designed to provide seamless care to people leaving hospital. The purpose of the evaluation was to identify if this model achieves the expected standard of care for clients being discharged from the hospital to the community.

Hospital readmission rates in the first month and overall went down in the year following the move of the discharge planning service to a community based location as compared with the year before the service location change.

Basing discharge planning services with an agency that also provides community based mental health services provides a direct connection to services for people being discharged from hospital.

The people leaving an acute care inpatient unit in this evaluation had very different characteristics from those leaving tertiary care inpatient units. Planning for services is most effective when the characteristics of the target group are known.

Formal evaluation needs to be built in before new programs are started. This project was limited as the funding for evaluation only became available after the new program had been in place for a year.

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Bluewater Health and Sarnia-Lambton CMHA

Compared with other developed countries, Canadian government spending on mental health as a percentage of its total health expenditure (6.1%) is lower than most. At a provincial level, in 2003-2004, the Government of Ontario spent only 5.3% of its health budget on mental health, the third lowest of all Canadian provinces.[11]

Over the last two decades, Ontario has undergone a fundamental reform of mental health care. MOHLTC's *Making It Happen* document provides the implementation plan for moving towards key characteristics of a reformed mental health system. A major component of the reform has been the move towards community mental health care with a corresponding reduction in the number of psychiatric hospital beds available. Despite this shift, government spending on community mental health care continues to be disproportionately low. In the 2006-2007 fiscal year, roughly $39 was spent on community-based mental health for every $61 spent on hospital-based services.[12]

The 2008 Annual Report of the Office of the Auditor General comments that this level of funding for community mental health is inadequate to meet the needs of people with serious mental illness living in the community. The report notes that people discharged from psychiatric hospitals into the community may not have the supports they need, which could in turn lead to higher rates of hospitalization, police intervention or emergency room visits.

A complicating factor is the serious shortage of supportive housing units. Wait times range from one to six years, and the supply of such units is spread unevenly across Ontario, with some regions experiencing significant vacancy rates while others face a severe shortfall in the number of units required.[13]

In any given year, the estimated percentage of Canadians who experience major depression ranges from 4.1% to 4.6%, while anxiety disorders are estimated to affect 12.2% of the population.[14] The percentage of Ontarians who access services for mental health reasons is only 8.7%,[15] indicating that people in need don't always access the services they require.

The MOHLTC organized the province into 14 Local Health Integration Networks (LHINs) in 2006, to develop a more integrated health care system with better access to services and coordination of those services at the local and provincial level. It has been two years since the LHINs started transitioning towards full responsibility for local health services, which has involved significant reorganization of services, making the establishment of new programs with new government investments that much more complex.

Each of these broad contextual issues influences the capacity of the community mental health system to provide the best possible care to consumer/survivors.

A factor which influenced the extent to which SEEI investigators could draw study conclusions was the variability in the type and quality of data they could collect at the system and program levels. This issue has also been referenced in the report's further research section.

11 "Expenditures on Mental Health and Addictions for Canadian Provinces in 2003/04" by Philip Jacobs, et al; The Canadian Journal of Psychiatry, Vol 53, No 11, May 2008.

12 2008 Annual Report of the Office of the Auditor General of Ontario, Chapter on Community Mental Health.

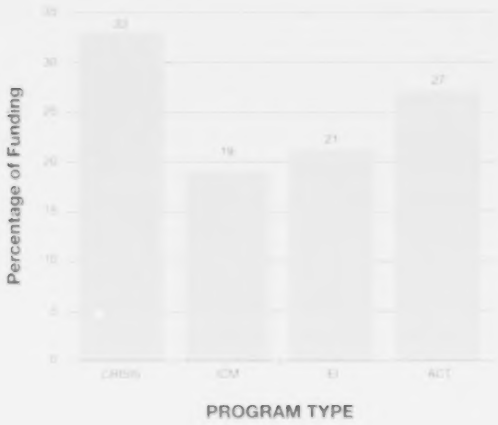
13 2008 Annual Report of the Office of the Auditor General of Ontario, Chapter on Community Mental Health.

14 Public Health Agency of Canada. A Report on Mental Illnesses in Canada. Ottawa, Canada [Online]. Available at: http://www.phac-aspc.gc.ca/publicat/miic-mmac/chap_1-eng.php. Originally cited in Offord DR, et al. One-year prevalence of psychiatric disorders in Ontarians 15 to 64 years of age. The Canadian Journal of Psychiatry, Vol 41, pp. 559-563, 1996, and Bland RC, et al. Period prevalence of psychiatric disorders in Edmonton. Act Psychiatr Scand 1988; 77 (Suppl 338): 33-42.

15 "Service Use for Mental Health Reasons: Cross-Provincial Differences in Rates, Determinants, and Equity of Access," by Helen-Maria Vasiliadis, et al.; The Canadian Journal of Psychiatry, Vol 50, No 10, September 2005.

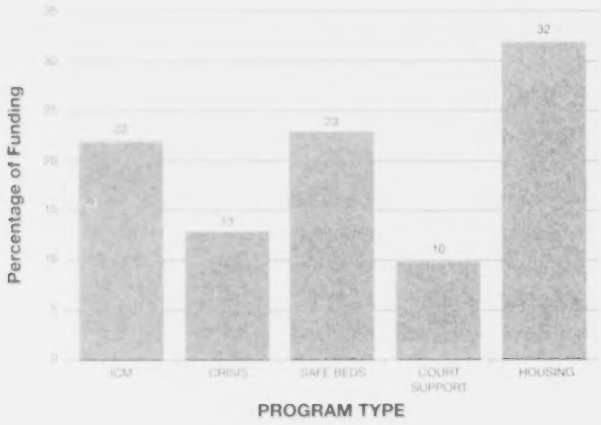
This appendix provides information about spending by program type according to whether the funds were received from the Services Enhancement or ACCORD initiatives. Each funding initiative had distinct goals for how the money should be used.

Graph 9: ACCORD Spending by Program Type (% of $117 million in total funding)



SOURCE: Michael Barker, Ministry of Health and Long-term Care, March 2007, "Funding overview for LHINs, MBarker, Mar 1"

Graph 10: Services Enhancement Spending by Program Type (% of $50 million in total funding)



SOURCE: Michael Barker, Ministry of Health and Long-term Care, March 2007, "Funding overview for LHINs, MBarker, Mar 1"

Appendix A:
Types of Programs Funded

This appendix provides an overview of the different kinds of programs that were funded through the Federal Health Accord for Home Care and the Service Enhancement Initiative.

ACT – ASSERTIVE COMMUNITY TREATMENT TEAM:
ACT is a widely implemented model for delivering mental health services in the community. ACT was developed as an alternative to hospitalization for people with serious mental illness. It provides ongoing, individualized, intensive support and helps clients develop the skills they need to live in the community. In the ACT model, a multidisciplinary team provides a full range of services to a roster of clients (about 80 to 100), with each team member contributing his or her professional skills according to need. ACT team services are available 24 hours per day, seven days per week; and the services provided to the clients are ongoing and unlimited in duration.
Study: Assertive Community Treatment (ACT) Fidelity and Evaluation

ICM – INTENSIVE CASE MANAGEMENT:
ICM is another model for providing people with serious mental illness with intensive services and long-term support in the community. ICM helps clients to achieve personal goals, build informal supports, and access community resources. Individual case managers provide assessment, counseling, and advocacy; and link clients with other treatment and rehabilitation services such as social recreation, employment programs, and supportive housing. Unlike ACT, ICM does not typically provide round-the-clock services, although some ICM programs in Ontario offer extended hours of service on evenings and weekends.
Study: An Evaluation of the Implementation and Outcomes of the CMHA, Ottawa Court Outreach Program

EI – EARLY INTERVENTION:
Early intervention programs provide support services and specialized treatment to people who are in the first stages of experiencing a psychotic disorder and their families. If individuals with psychotic disorders are treated at the earlier stages, there is a higher chance that the most disabling elements of psychotic disorders can be either reduced or eliminated.
Study: The Matryoshka Study, Early Intervention Programs

CRISIS PROGRAMS:
Crisis programs provide services to people experiencing a crisis, whether psychosocial in nature or as a result of serious mental illness. They serve to divert people from unnecessary inpatient hospitalizations, link clients with other services as needed and enhance community tenure. Crisis programs offer services at various levels of intensity. Crisis programs include: telephone crisis services, mobile crisis units, crisis residential services and psychiatric emergency/medical crisis services in hospitals.
Studies: Waterloo Wellington Crisis System Evaluation: Understanding the Impact of Enhanced Programs and Coordination; Review of Crisis Services; An Evaluation of an Integrated Crisis-Case Management Service Model; and the Impact Study.

SAFE BEDS:
Safe beds form part of a larger crisis system. They provide clients in crisis with support and a short-term place to stay in a safe, supervised non-hospital setting if they need to be away from their regular environment. Having access to safe beds allows clients to stabilize, address problems, and connect with needed services. Safe beds can also serve to divert clients away from either the justice sector or from being hospitalized.
Study: Waterloo Wellington Crisis System Evaluation: Understanding the Impact of Enhanced Programs and Coordination

COURT SUPPORT PROGRAMS:

Court support programs provide a wide range of services to individuals who could benefit from mental health services and who are at various stages of contact with the justice system. An individual's earliest point of contact with the justice system might occur with the police. At that point, court support programs may link the individual to mental health services as an alternative to charges and incarceration. Court support programs also provide services to individuals who have been charged, as well as those who have been convicted of a criminal offence and who could benefit from mental health services.

Study: The Matryoshka Study, Court Support Programs

SUPPORTIVE HOUSING:

Supportive housing provides people experiencing mental illness with a place to live in the community. The housing is widely dispersed in the community, and consumers are provided with choice, individualized supports at different levels of intensity, and assistance in finding and maintaining housing. Support services are also offered to people who are homeless or at risk of becoming homeless. Supportive housing is mainly a place for clients to live, not a place for treatment. There are no restrictions on how long clients can remain in supportive housing.

Appendix E
Definition of Continuity of Care from Study G/I

Studies G/I and D defined "continuity of care" according to six different measures:

Timeliness of Services: This indicator was calculated using the number of each client's services that were referred to other programs and the number of those services for which the referral was accepted within 30 days.

Comprehensiveness of Services: This indicator was calculated using the proportion of needed services that were being used by each client.

Intensity of Services: To measure the intensity of service, the proportion of needed services for which there was a match between the amount of services needed and the amount used by each client was calculated.

30-Day Gaps in Service: A gap in service was defined as a 30-day period during which the program lost contact with a client who needed services.

Coordination of Services: This indicator reflected the ratio of referrals that were accepted to those that were made for each client.

Accessibility: This indicator represented the proportion of needed services that were within a one-hour traveling distance of where the client lived.

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